MEMO

Questions and Answers
Related to the New Hospice Conditions of Participation
Effective 12/2/08

CORRECTION FROM JANUARY 2009 BUREAU TALK

It has come to the attention of the Bureau that two of the questions published in the January 2009 Bureau Talk was answered incorrectly.

INPATIENT DAYS:
The number of inpatient days is not to exceed 20% of the total hospice days. Does this percentage only apply to Medicare inpatient days? Does this include respite days?

CORRECT ANSWER: per CMS, "…The total number of inpatient days used by Medicare beneficiaries who elected coverage in a 12-month period in a particular hospice may not exceed 20% of the total number of hospice days consumed by this group of beneficiaries, refers to both general inpatient and respite levels of care." (42 CFR 418.108(d))

MEDICAL DIRECTOR:
Can the medical director act as the attending physician if the patient chooses and sign the election statement in both spots as the attending and the medical director?

CORRECT ANSWER: The patient signs the election statement not the physician. Yes, the medical director can also be the patient's attending physician. The medical director can sign the certification as both the attending and the medical director. It needs to be very clear in the medical record that the *patient* has chosen to use the medical director as his/her attending physician.

Administrator:

1) What are the required qualifications for the hospice administrator?
   A: Per 418.100(b), "…A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee and possess education and experience required by the hospice's governing body."
   Neither the federal or state regulations specifically outline what the required qualifications are for the administrator other than that they have education and experience as outlined by the governing body. Therefore, the bureau would look toward the agency's policy to define what they identify as required education and experience for the administrator of the agency.

AIDES

1) With the new CoPs, does a hospice aide have to have special certification?
   A: No, a hospice aide does not require any special certification. Nothing has changed regarding the qualifications for aides in hospice. As before, in order to be a hospice aide, the person simply needs to pass the state approved aide competency exam and skills test. This exam and skills test is the same one that has been in use/revised since July 1, 2004.
2) How do you calculate the 12-month period when referring to aide in-service training?
   A: In regards to in-service training, 418.76(d) states, "A hospice aide must receive at least 12 hours of in-service training during each 12-month period. In-service training may occur while an aide is furnishing care to a patient." Per the Interpretive Guidelines, hospices may fulfill the annual 12-hour in-service training requirement on a calendar year basis, an employment anniversary basis, or a rolling 12 month basis as long as each aide meets this in-service training requirement. Hospice aide in-service training, that occurs with a patient in a place of residence, supervised by an RN, can occur as part of the every 14-day supervisory visit, but the exact new skill or theory taught must be documented. In-service training taught in the patient's environment should not be a repetition of a basic skill."
3) What are the requirements for the supervision of the aide, i.e., does the aide have to be present or not at the supervisory visit?
   A: Per 418.76(h)(1)(i), "A registered nurse must make an on-site visit to the patient's home no less frequently than every 14 days to assess the quality of care and services provided the …. The hospice aide does **NOT** have to be present during this visit." However, per 418.76(h) (2), "A registered nurse must make an **annual on-site visit** to the location where a patient is receiving care in order to observe and assess each aide **while he or she is performing care."**

Durable Medical Equipment (DME)

1) What if a DME company is not accredited but is working towards that accreditation?
   A: The bureau/surveyors would expect that the agency have a letter in its file for proof that the DME is working toward certification by September 30, 2009. Per 418.106(f) (3), Interpretive Guidelines, "….All DMEPOS (Durable Medical Equipment Prosthetics, Orthotics and Supplies) are required under separate rulemaking to be accredited by September 30, 2009, in order to receive Medicare payment. If a hospice has a contract with a DME supplier (that has a Medicare supplier billing number), the hospice should have a letter in its file form the DME supplier stating that the DME supplier is accredited.) If the hospice contracts with a DME supplier that only serves hospices, (therefore no Medicare supplier number), the hospice will still need to have a letter in its file from the DME supplier stating that the DME is accredited. If the hospice owns its own DME, no accreditation is needed."

Hospice in a LTC Facility

1) We know the hospice has regulations that mandate a coordinated plan of care when a hospice patient resides in a long term care facility (LTC). What responsibility does the LTC facility have?
   A: The State Operations Manual (SOM), Appendix P – Survey Protocol for **Long Term Care Facilities**, Part I, was revised 04-10-09 to include provisions for residents receiving hospice services. These revisions were effective April 10, 2009 with an implementation date of April 10, 2009. It states, "When a facility resident has also elected the Medicare hospice benefit, the hospice and the nursing home must communicate, establish, and agree upon a coordinated plan of care for both providers which reflects the hospice philosophy, and is based on an assessment of the individual's needs and unique living

situation in the facility. The plan of care must include directives for managing pain and other uncomfortable symptoms and be revised and updated as necessary to reflect the individual's current status…."
To review these entire revisions please refer to the CMS website at www.cms.hhs.gov/Transmittals/2009Trans/list.asp. The transmittal you are looking for is R41SOMA.

2) Does the hospice have to have one person specifically designated as a contact person between the LTC facility and the hospice agency?
A: Per 418.112(e), The hospice must: (1) Designate a member of each interdisciplinary group that is responsible for a patient who is a resident of a SNF/NF or ICF/MR. The designated interdisciplinary group member is responsible for: (i) Providing overall coordination of the hospice care of the SNF/NF or ICF/MR resident with SNF/NF or ICF/MR representatives; and…" The interpretive Guidelines state, "The intent of this regulation is for the hospice IDG to designate a member responsible for overseeing and coordinating the provision of care between the hospice and the facility. This person may or may not be the hospice RN responsible for the coordination of patient's hospice care in the facility. It may also be the physician, social worker or counselor member of the IDG…"

Infection Control

1) Whom all does the infection control program in our agency have to target?
A: Per 418.60, "The hospice must maintain and document an effective infection control program that protects **patients, families, visitors, and hospice personnel** by preventing and controlling infections and communicable diseases." Per the Interpretive Guidelines, the hospice infection control program must identify risks for the acquisition and transmission of infectious agents in **all settings where patients reside.** There needs to be a system to communicate with all hospice personnel, patients, families and visitors about infection prevention and control issues including their role in preventing the spread of infections and communicable diseases through daily activities."
2) What must the infection control program entail?
A: 418.60(b) states, "The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases…" Per the Interpretive Guidelines, "Examples of infection control practices that the hospice may use include monitoring work related employee illness and infections, analyzing them in relation to patient infections, and taking appropriate actions when an infection or communicable disease is present to prevent its spread among staff, patients, family and visitors. Surveillance data should be routinely reviewed and monitored. Appropriate corrective actions need to be taken based on the data analysis. The hospice must use this information as a part of its QAPI program."

Initial Assessment/Comprehensive Assessment

1) What information is expected to be gathered during the initial assessment? What makes it different than the comprehensive assessment?
A: Per the Interpretive Guidelines 418.54(a), the purpose of the initial assessment is to gather the critical information necessary to treat the patient/family's immediate care needs. The assessment needs to take place in the location where hospice services are being delivered. The initial assessment is not a "meet and greet" visit whereby the hospice introduces itself to the patient/family and begins to evaluate the patient's interest in and appropriateness for hospice care. It MUST assess the patient's immediate physical, psychosocial, emotional and spiritual status related to the terminal illness and related conditions. **The initial assessment is necessary to gather the essential information necessary to begin the plan of care and provide the immediate necessary care and services.** It must be completed within 48 hours after the election of

hospice care unless the physician, patient, or representative request that the initial assessment be completed in less than 48 hours.
The comprehensive assessment must be completed no later than 5 calendar days after the election of hospice care. The comprehensive assessment is much more detailed. Per 418.54(c), "The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process." For example, in addition to screening the patient for the presence of pain, a comprehensive assessment of the patient's pain based on accepted clinical standards of practice may necessitate gathering more detailed information such as, history of pain and its treatment, characteristics of pain, physical examination, current medical conditions and medications and the patient/family's goals for pain management, etc.

Medications:

1) Are the medication reviews required to be done every 15 days if there are no changes in the medications?
   A: Per 418.54(c)(6), Interpretive Guidelines, "…The hospice should review each patient's medications and monitor for medication effectiveness, actual or potential medication-related effects, duplicate drug therapy and untoward interactions **during each update** to the comprehensive assessment, **and as new medications are added or changed,** or patient's condition changes." Per 418.54(d), "…The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days." The agency must have documentation that the medication reviews were done.
   NOTE: Whenever the state regulations are more stringent than the federal CoPs, the agency must adhere to the state requirement. In this instance, the state regulations ML158) states, "The plan shall be reviewed and updated by the interdisciplinary group at a minimum of every two weeks. These reviews shall be documented in the patient record." Therefore, medication reviews in Missouri are required to be done every 14 days.
2) Would a nurse who takes and passes the Hospice and Palliative Nurse exam qualify and meet the requirements of the regulation at 42 CFR 418.106(a) Managing drugs and biological?
   A: Per 418.106(a), Interpretive Guidelines, " …Individuals with education and training in drug management may include: licensed pharmacists; physicians who are board certified in palliative medicine; **RNs who are certified in palliative care**; …"
   A representative from the National Board for Certification of Hospice & Palliative Nurses states, "…the NBCHPN certification in hospice and palliative care is the palliative care certification referenced in the interpretive guidelines to the regulation 42 CFR 418.106….this is one measure CMS is employing to ensure that the RN has the ability to evaluate a drug profile…."
3) In 418.106(e) (2), it states, "At the time when a controlled substance is first ordered, the hospice must…" If we admit a patient who is already on a controlled substance (a common situation) should we treat that as if it is a first order of the mediation and provide the policy and teaching per regulation, or do we do that only if we are starting a controlled medication on a current patient?
   A: The regulation states, "At the time when controlled drugs are first **ordered** the hospice must:" If the patient is on controlled drugs when they elect the hospice benefit the hospice will obtain **orders** for those drugs on admission and would; therefore, have to provide the required information at the time of admission. IF the patient was not on controlled drugs on admission then the required information would not have to be provided until symptom management required the physician to **order** the drugs.

The patient may have been on controlled drugs prior to admission but that does not relieve the agency of the responsibility to obtain an order for those drugs when the patient is admitted because the hospice would then be getting the new orders. In summary, if the patient is on controlled substances at the time of admission the agency would need to suffice the regulation with giving copies of your policies and procedures, etc.

Medical Director:

1) I know there is to be only one Medical Director of the hospice, the one that supervises the other physicians; however, can these other physicians serve as the physician member of the IDG teams?
   A: Yes. For example, you can have 4 different IDG groups that meet, and all have their own physician member; however, there can only be one that is designated as the Medical Director of the hospice agency. The other 3 would be called "hospice physicians" or the regulations refer to them as "hospice physician employees".
2) Can only the Medical Director sign forms as Medical Director or may the Medical Director give permission for the other physicians to sign on his behalf?
   A: Each separate hospice physician can sign the certifications, orders, etc. but must sign their own name. The regulations stipulate that there is only one physician named as Medical Director because he/she is ultimately responsible for meeting the Condition of Participation at 42 CFR 418.102 Medical Director.
3) Is there a limit to the number of other physicians you may contract with and pay to serve as the IDG team members?
   A: There is nothing in the regulation that would preclude any number of hospice physician employees.
4) Can a physician serve as a "hospice physician employee" for more than one hospice at the same time?
   A: The bureau is aware that there are physicians that serve several hospices. We suggest that if hospices have a question about such practices that they contact the Office of Inspector General (OIG). The national hotline number is 1-800-477-8477. This is an issue that the bureau will be discussing with the OIG in the near future.

Physician Services

1) Is it true that physician services can now be contracted?
   A: Per 418.64, "A hospice must routinely provide substantially all core services directly by hospice employees. These services must be provided in manner consistent with acceptable standards of practice. These services include nursing services, medical social services, and counseling. **The hospice may contract for physician services** as specified in paragraph (a) of this section."

QAPI

1) What is the governing body's role in the QAPI program?
   A: Per 418.58, "….The hospice's governing body must ensure that the program: reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance…". In other words, oversight responsibility lies with the governing body. The results of the QAPI program must be transmitted to the governing body to fulfill its responsibility of ensuring an effective QAPI program. The governing body is responsible for regular review and use of the QAPI analyses to make systemic improvements.
   Per 418.58(b) (3), "The frequency and detail of the data collection must be approved by the hospice's governing body." Per the Interpretive Guidelines, "The governing body may assume hands-on control of the QAPI program to ensure that the program is in compliance with this rule, or it may choose to appoint one or more individuals to handle

the structure and administration of the QAPI program. The governing body retains ultimate responsibility for the actions of the designated individual(s)."

CFR 418.58(e) further defines the governing body's role in the QAPI program. It states, "the hospice's governing body is responsible for ensuring the following: 1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually, 2) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness, and 3) That one or more individual(s) who are responsible for operating the quality assessment and performance improvement program are designated.

Revocation/Discharge

1) What paperwork is required of the agency if a patient revokes or is discharged?
   A: Per 418.104(e)(1)(2) & (3), "If the care of a patient is **transferred** to another Medicare/Medicaid-certified facility, the hospice must forward, to the receiving facility, a copy of – (i) The hospice discharge summary; and (ii) The patient's clinical record, if requested. If a patient **revokes** the election of hospice care, or is **discharged** from hospice in accordance with 418.26, the hospice must forward to the patient's attending physician, a copy of – (i) The hospice discharge summary; and (ii) The patient's clinical record, if requested. The hospice discharge summary as required by (e) (1) and (e) (2) of this section must include- (i) A summary of the patient's stay including treatments, symptoms and pain management; (ii) The patient's current plan of care; (iii) The patient's latest physician orders; and (iv) Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility.

   Note: The following requirements are also mandated per regulation:

   1) Per CFR 418.28 (Subpart B), "…To **revoke** the election of hospice care, **the individual or representative** must file a statement with the hospice that includes the following information: (1) A signed statement that the individual or representative revokes the individual's election for Medicare coverage of hospice care for the remainder of that election period. (2) The date that the revocation is to be effective…."
   2) Per state regulations (ML104), if a patient **transfers** to another provider, including another hospice provider, the hospice transferring care shall provide to the receiving provider pertinent written information which shall include at a minimum: A. Current medication profile; B. Advance directive (if applicable); and C. Problems that require intervention or follow-up. ML106, ML107, and ML108 regarding hospice patient **discharge** state: "…The hospice shall immediately notify the patient or representative and shall include the date that the discontinuance is effective; Patient's/family's continuing care needs, if any, are assessed at discharge, and the patient/family are referred to appropriate resources; and The physician shall be notified in all instances of discontinuance of hospice care and such notification shall be documented in the patient record."

Social Work

1) 418.114(b)(3)(ii) states the social worker has to have "one year of social work experience in a health care setting;". If a social worker worked as an intern for one year would this qualify as the one year social work experience?
   A: The bureau has determined that if a social worker worked as an intern for one year this would meet the requirement of one year of social work experience.

Waivers

1) Is it possible for a hospice to receive a waiver for dietary counseling?
   A: There is a waiver available for the requirement for physical therapy, occupational therapy, speech-language pathology, and dietary counseling. Per 418.74, "… A hospice located in a non-urbanized area may submit a written request for a waiver of the requirement for providing physical therapy, occupational therapy, speech-language pathology, and dietary counseling services. The hospice may seek a waiver of the requirement that it make physical therapy, occupational therapy, speech-language pathology, and dietary counseling services (as needed) available on a 24 hour basis. The hospice may also seek a waiver of the requirement that it provide dietary counseling directly…"
   There are specific criteria that must be met before a waiver will be granted. This waiver does not waive the hospice's responsibility to provide PT, OT, SLP, and dietary counseling; only to provide them (as needed) on a 24 hour basis.